Arkansas Health Information Exchange Finance Workgroup

FEBRUARY 18, 2010

ARKANSAS CENTER FOR HEALTH IMPROVEMENT

MAIN CONFERENCE ROOM

11:30 AM TO 1:30 PM

Perceptions of HIT/HIE Benefits: Patients & Providers

What do PATIENTS Think?

- Studies that go back almost a decade show that patients see value in both HIT (mainly EHRs) and in HIE (especially for their own personal access, and for doctors gathering information quickly during an emergency situation)
- Patients' perceived value has grown over time

- How is this information applicable for HIE financing/how do we use this information to help create financing opportunities?
  - How do we use the info we have? What additional information do we need to know?
  - What financing limitations & opportunities are revealed by these studies?

What do PATIENTS Think?
Markle Foundation – June 2003

Over 70% believe PHR would improve quality of health care

Based on responses to the question, "I think that having my health information online would…"

- Clarify doctor instructions – 71%
- Prevent medical mistakes – 65%
- Change the way I manage my health – 60%
- Improve quality of care – 54%

Over two-thirds would use PHR features if available

Based on responses to the question, "If you could keep your medical records online, which of the following would you do?"

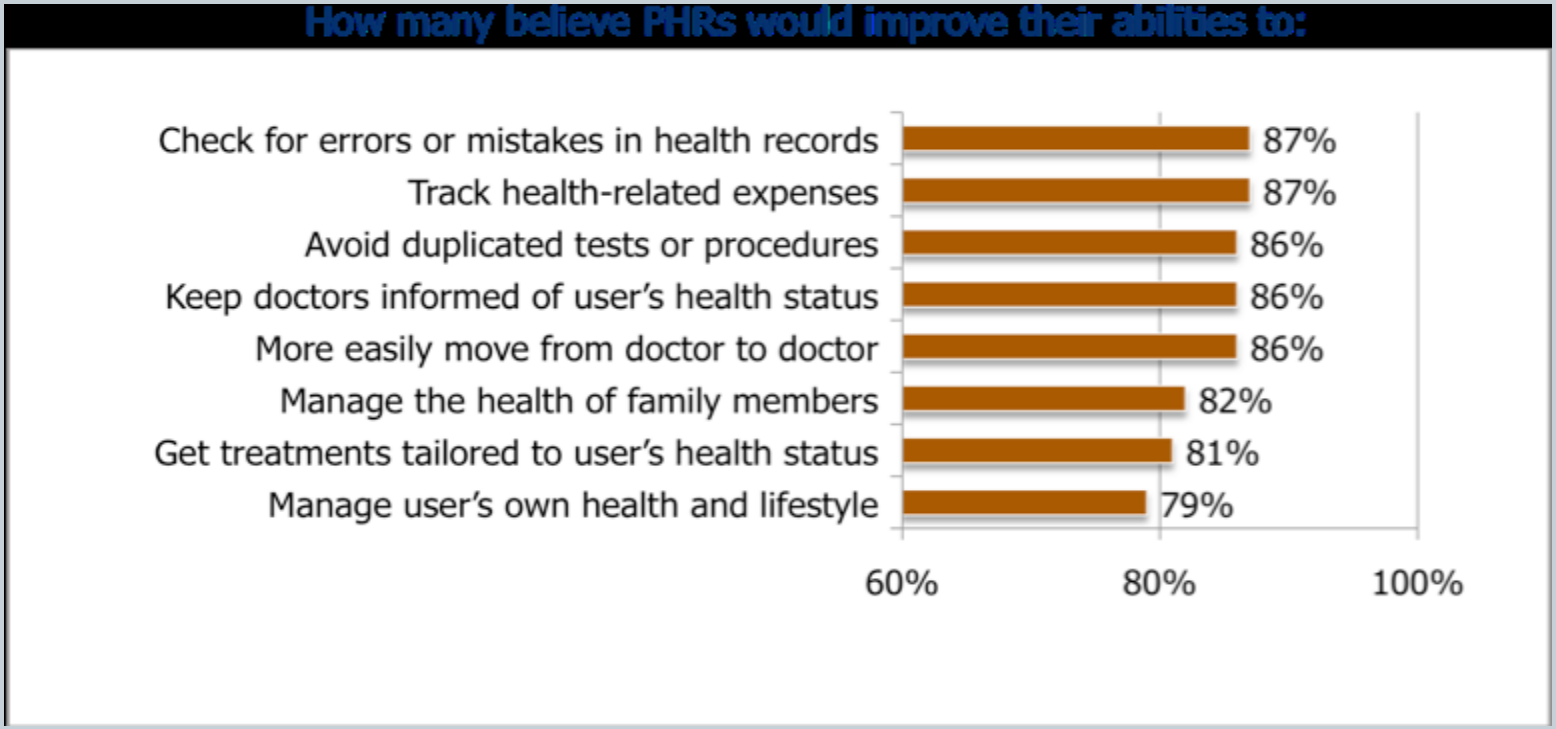
- Email doctor – 75%
- Store immunization records – 69%
- Transfer info to specialist – 65%
- Lookup test results – 63%
- Track medication use – 62%

What do PATIENTS Think?
eHealth Initiative – 2006 (1,000 adults - AL, FL, LA, MS, TX)

- Support is extremely strong for HIE – 70% favor, 21% oppose
- The more consumers learn about HIE, the stronger their support is
- Guidance about communicating about HIE: focus on security, how it works, patient permission, who has access, benefits to patients/providers
- Messages that resonate:
  - Having access in an emergency – 46%
  - Having access when you are out of state – 14%
  - Having access when you visit your doctor – 10%
  - Transfer lab results, reports or x-rays between providers – 7%
- Misperceptions are common: almost half think doctors already use EHR, majority believe doctors have off-site backup

What do PATIENTS Think? Connecting for Health/Markle Fdtn – June 2008

PHR has high perception of value: When the general public was asked how use of an online PHR service would affect individual handling of health and health care, large majorities said such services could improve several activities "a great deal" or "somewhat."



What do PATIENTS Think?

Kaiser & Harvard School of Public Health – April 2009
(1,238 adults, conducted in both English & Spanish)

- Majority of Americans do not believe EMRs will lower health care costs
  - 34% think it will increase costs
  - 36% think it will keep costs about the same
  - 22% think it will decrease costs
- 72% of think it is at least somewhat likely that doctors would do a better job of coordinating care
- 75% think it is at least somewhat important for doctors to use electronic records
- 65% think it is at least somewhat likely that overall quality of medical care would be improved and 62% believe it is at least somewhat likely that overall quality of medical care for them & their family would be improved
- 76% believe it is at least somewhat likely that an unauthorized person would get access to their medical records
- 1 in 10 say they have been able to access test results online
- 46% say doctors enter their information on a computer during a visit

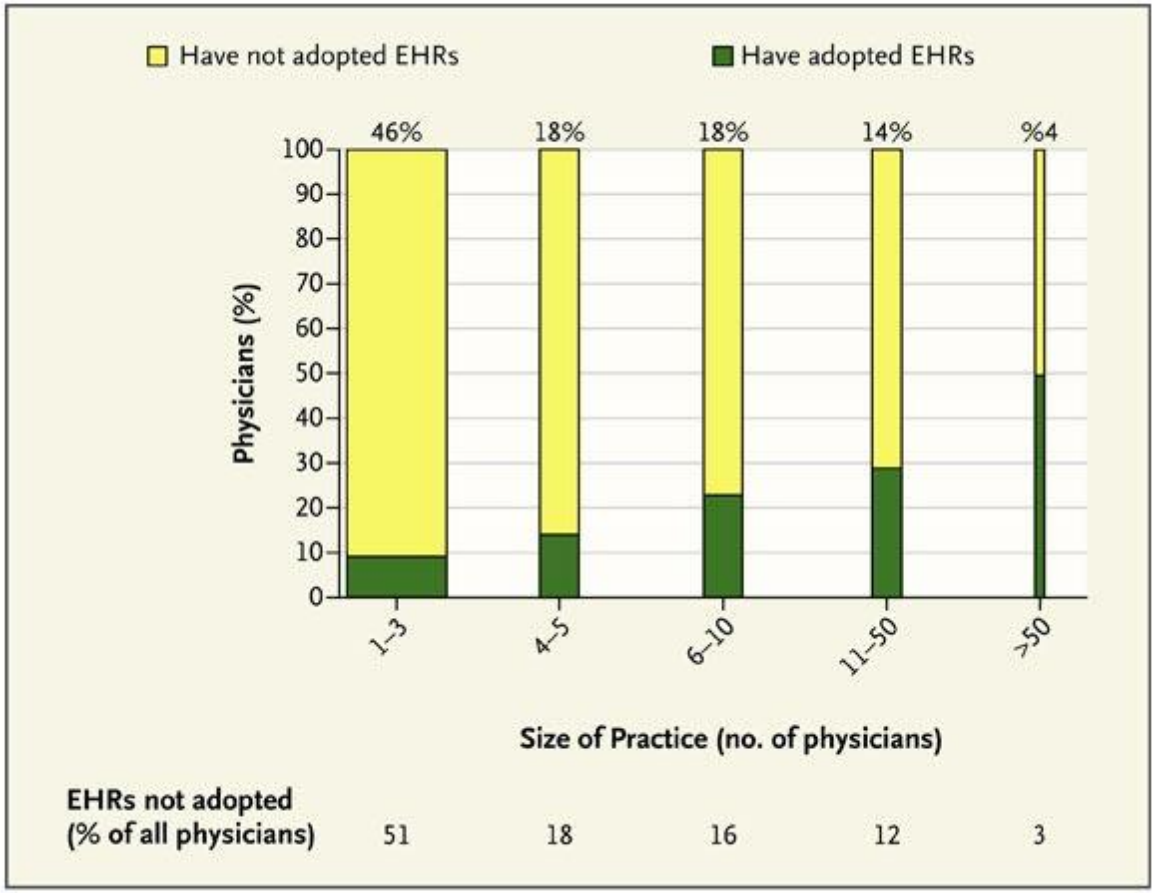
What do PROVIDERS Think?

- Not nearly as much information available about what providers think about HIT and HIE
  - Studies are more recent and less comprehensive
  - Focus much more on EHRs than HIE
  - What is available show that there is not even widespread acceptance of EHR, much less HIE
- Again, we need to think about how this information is applicable for HIE financing/how do we use this information to help create financing opportunities?
  - How do we use the info we have? What additional information do we need to know?
  - What financing limitations & opportunities are revealed by these studies?

What do PROVIDERS Think?
NEJM – January 20, 2010

Rates of Adoption of Electronic Health Records According to Practice Size.

The percentage shown above each bar is the proportion of physicians who work in a practice of the given size. The green portion of each bar represents the percentage of physicians in a practice of a given size who have adopted at least basic electronic health records (EHRs), and the yellow portion represents the percentage of physicians who have not adopted EHRs.[2] For each practice size, the percentage of physicians who have not adopted EHRs relative to the total number of physicians in practice is shown at the bottom. Physicians in the smallest practices account for more than 50% of those who have not yet adopted EHRs, whereas physicians in the largest practices account for only about 3%.



What do PROVIDERS Think?

Perspectives in Health Information Management (AHIMA) – Winter 2010 (Iowa Research Network – four practices)

- A 2008 survey of ambulatory care physicians found that 25 percent of respondents were unfamiliar with PHRs and 60 percent were unaware of whether any of their patients maintained PHRs.[22] The study also showed that paper-based PHRs were currently the most popular among patients. Very few physicians in the survey reported an ability to integrate PHR information into their EMRs, and physician attitudes regarding the use of PHRs were not addressed.
- Overall, focus group participants seemed optimistic regarding the potential for PHRs to increase efficiency and decrease healthcare costs.
- Providers voiced two main concerns: accuracy and privacy. Providers were concerned about the validity of information contained in PHRs and the implications of bad information for treatment. The privacy concern entailed inappropriate and unauthorized access to sensitive medical information contained in PHRs.
- Providers expressed the concern that patients may not know what is appropriate to put in their health record or may input information that has not been verified by a professional.
- Participants were also adamant that insurers not be involved with PHRs and that claims data should not be used to populate PHRs.
- The potential for PHRs to improve healthcare is significant. However, the task of securely, efficiently, and effectively incorporating PHRs into the current medical system and society will be challenging. This study suggests that providers predominantly view PHRs as a backup source of medical information secondary to the patient's medical record as opposed to a tool for patients. While providers believe PHRs have the potential to decrease errors and increase efficiency, they are concerned about how to integrate PHRs into patient appointments that are already too short.

What do PROVIDERS Think?

Montgomery County (MD) HI Exchange Collaborative – February 2009

- Most primary care physicians (PCPs) surveyed saw particular utility in having access to patients' health records from a hospital emergency department (ED), laboratory tests, and specialty care.
- They reported that patients would benefit from not having to carry the sole responsibility of transmitting information about their treatment – which they may or may not fully understand – between providers.
- All participant groups discussed how HIE could enhance patient safety through availability of information about medications, allergies, and diagnoses…
- Providers reported that having the information at-hand would decrease time spent searching for files, calling other providers, and faxing information.
- Features wanted by providers:
  - Ability to access information outside medical office & outside office hours
  - Flags/alerts about drug interactions, side effects and allergies
  - Access to lab results, progress notes, x-ray results, medical history, medications, etc.
  - Ability to scan and view radiographic diagnostics and medical imaging firsthand
  - Connections to cancer screenings and immunizations provided by county/other offices
  - Real-time online access and use – more than just a "reporting tool"
  - Ability to track who viewed/entered data, and for what purpose
  - Training to use, computer and IT support
- Physicians question that HIE will be able to achieve the high & multiple goals set for it
- Providers more likely to support HIE if they have exposure to EHRs now

Perceptions of HIT/HIE Benefits
How does this help the HIE Financing Strategy?

- What do patients and providers think the benefits of HIT/HIE are now and can be in the future?
  - Patients are more "bought in" to HIE than providers
  - EVERYONE sees at least some benefit to HIE, but also have concerns
  - Willingness to pay is not necessarily tied to perceived benefit
- Why do we care? What are the specific implications for financing an HIE system? How can this help us frame the discussion about HIE financing?
  - Need to know value/financial worth to users, then use that value to help assess financing climate and abilities
  - What are the gaps in benefit vs. what is currently paid?
  - What are gaps between perceived and actual benefit?
  - How much are people willing to pay – can't overvalue or undervalue
  - Help decide cost division based on perceived/actual benefits

Finance Model Details: Vermont, New York, Delaware

Pros, Cons, Comments & Questions

Finance Model Details – Vermont

PROS	CONS	?s/COMMENTS
- probably increased revenue stream every year because of increase in population/claims and costs each year - lots of different types of funding means better sustainability - if payment comes from payors, there is no disincentive for "users" to use it (vs if it were transaction-based), so docs, pharmacies, etc. are more likely to use it since they aren't paying - .2% per claim is small amount for payors to recover and still see financial benefit - as participation in HIE increases, revenue likely to increase	- if payors don't see efficiencies/savings of at least .2% per claim - fee-based needs additional infrastructure in order to know what to charge - basing money on claim-paid dollar means that the exact same claim will be paid a different amount depending on networks & their agreements (fixed fee may give better budgeting idea) - Medicaid is going to be considering a transaction fee in order to help increase revenue - fees are not associated with member, so even if docs aren't using, payor still has to pay - paying % on net payment could actually see revenue decrease if reimbursements continue to decrease	- would Medicaid claims be approved just like other claims? - what is value to different users & payors? - possible incentive: if using HIE, will reimburse; if not using, could have a fine - there are other incentives around using EHRs that are not associated with this - providers can't base fees on Medicaid reimbursement – if docs have to pay to participate it will be a problem NEED ANSWERS: - What is volume of claims? - What is % fee based on? - What is staff size & structure? - What is relationship with GE (infrastructure)?

Finance Model Q&A – Vermont

- What is volume of claims?
  - about 1.4 billion claims in the last year
- How much has been raised in HIT Fund?
  - $2.4mm in the last year
  - Way the fund works has changed dramatically since inception:
    - first nine months, collected and distributed by Dept of Insurance
    - then the State decided to get involved directly, so the money is collected by the state generally and they release it "whenever they want"
    - VITL no longer the sole recipient, money has started to get siphoned off for other uses, some not really HIT-related
- What is % "tax" based on – billed amount, allowed amount, amount pd by insurance co, etc.
  - amount actually paid out by insurance
  - paid on services provided in VT by VT providers only (in a state where approx 20% of services actually happen outside of VT – Boston, Dartmouth-Hitchcock in NH, etc.)
  - companies based in VT are good about paying (mostly because regulated & enforceable by the Dept of Insurance)
  - have had to fight national companies (Aetna & Cigna) quite a bit to get them to pay, despite it being a law to pay in order to do business in VT
- How are providers "dividing up" between the paying options? How is % participation (if they choose that) figured?
  - the only choice really has been the fee per claim (the .2% of each claim)
  - haven't needed to worry about the % option

Finance Model Q&A – Vermont

- What is staff size? How is it set up?
  - VITAL is nonprofit public-private partnership, board is very diverse representing numerous stakeholders
  - started with 2 staff in 2006, have increased staff greatly in last year, now have 10 and anticipate hiring a number of additional project managers as future funding is available
  - President/CEO, VP-External Affairs, VP-Policy & Special Projects, VP-Finance, Dir of Technology Services, Dir of Outreach & Business Development, Dir of Program Implementation, Office Manager, Executive Assistant
- How many (%) of VT providers using HIE now?
  - hospitals all up & running (100%)
  - about 1/3 of primary care
  - overall about 10%
  - do not see that changing significantly
  - many older providers are retiring/aging out or have already done so; expect adoption to be slow in the future among the smaller providers
- Do Medicaid/Medicare claims get charged in any way?
  - Medicaid and Medicare are exempt because they do not have a CMS waiver to implement the "tax"; VT Medicaid is actually mandated to pay the $250,000 "contribution" but has not done so to date
- What is relationship w/GE?
  - Didn't talk to Becky about, but on 990s GE is major consultant/provider of services

Finance Model Details – New York

PROS	CONS	?s/COMMENTS
- bonds are cheap way of financing	- very hospital-centric, less applicable in Arkansas - do not seem to have much money for sustainability - if using general obligation bonds, would have to be voted on by public - life of bond would well outlast life of equipment - bonds must rely on some type of revenue stream in order to pay back, which would require legislation - revenue stream would have to be enough to pay back original obligation AND sustain the system	- can't use Medicaid money to pay off bonds - incentives will depend on revenue stream for bond obligations - exactly what would bonds pay for? - government taking lead in driving financing **NEED ANSWERS:** - Are bonds general obligation or special revenue? - Do the (non-hospital) providers play ball? What incentives do they have to participate?

Finance Model Q&A – New York

- Are bonds general obligation or special revenue?
  - 98% confident that these are all PIT-secured bonds (personal income tax)
  - HEAL NY is bond $$ given out as grants in numerous stages
- What incentives do providers have to participate?
  - In addition to built-in incentives, there is quite a bit of grant money available

Finance Model Details – Delaware

PROS	CONS	?s/COMMENTS
	- transaction fee could be a disincentive, especially for larger groups who are paying more - need to show more clear/specific return on investment	- in Arkansas, pharmacies pay 30-40 cents for any electronically-sent prescription whether it is ever filled or not - what is benefit to those participating? (in pharmacy example, incentive is compliance with federal law for tamper-proof prescribing) **NEED ANSWERS:** - What constitutes a "transaction" for the fee – uploading, accessing, transmitting order, payment of claim, etc. - What was logic used to come up with fee basis? - What is the pattern of use seen by the various providers? -Is there any data available from patients or providers about their happiness with use of the system?

Finance Model Q&A – Delaware

- What is process? Charges are based on volume/share of transactions; how is that tracked/accounted for?
- What constitutes a "chargeable transaction" – ie accessing/reading data, uploading data, transmitting order, etc.? Is transaction counted for sender or receiver, or both?
- The transaction fee is based on number of transactions and that % is applied to public sector funds. What was the thought process used to come up with what fee is based on (ie why that way)? Is payment % directly proportional to % use, or is it weighted somehow?
- What is pattern of use/participation? Has use changed by those paying more/less?
- Is there any data from providers or patients about their happiness with use of the system?
- NO ANSWERS YET - EMAILED DHIN

Finance Models – Working for Arkansas

- How can we use what we know about these models to help HIE financing work for Arkansas?
- Can we duplicate one state's approach or parts of one?
- How can we modify any or all approaches to make them better work for Arkansas?

HIE Players & Payers

HIE Players & Payers

- Individuals – Patients/Consumers
- Public Health
- Medicaid
- Other State Agencies & Programs
- Employee Benefit Division
- Private Insurers
- Labs
- Physicians, Clinics, Hospitals, Other Providers
- Data Users, Researchers, etc.

HIE: Players & Payers

- What do each of the players pay now? What benefits do they receive? What benefit could they receive?
- Is the benefit each receives worth more than, less than or equal to what they are currently paying for that benefit?
- What potential additional benefit do they see with HIE? What would/should/could they pay for that additional benefit?
- Is there a possibility of providing cost savings by shifting costs over to HIE to get the same information they pay for now?
- Which players pay less/more than their benefit? Is there a way to convert them to pay appropriately for that benefit?
- Even if everyone paid what they "should," is that enough to support HIE?

Financial Principles for HIE

Financial Principles for HIE